URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS AUG 3 1960

-60-027979

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 155

ENDED

1. PLACE OF DEATH
a. COUNTY ST CHARLES
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. CHARLES
Length of stay in 1b: VISIT
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 302 So. 2ND STR.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY St. Louis
c. CITY OR TOWN ST. ANN Mo
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 10408 ST. CHARLES RD.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First JAMES Middle J Last CULLINANE

4. DATE OF DEATH Month JULY Day 23 Year 1960

5. SEX M

6. COLOR OR RACE W

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH NOV 12 '92

9. AGE (last birthday) 67
IF UNDER 1 YEAR Months 8 Days 11
IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FUNERAL DIRECTOR

10b. KIND OF BUSINESS OR INDUSTRY MORTUARY

11. BIRTHPLACE (City and state or country) St. Louis Mo.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME WILLIAM F. CULLINANE

13b. MOTHER'S MAIDEN NAME CATHERINE MULLALLY

14. NAME OF HUSBAND OR WIFE HAZEL CULLINANE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 492-05-4334

17. INFORMANT Address HAZEL CULLINANE, ST. ANN, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) coronary arteriosclerosis — 5 yrs ?
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 5-23-60 to 7-23-60 and last saw her/him alive on 7-23-60
Death occurred at 9 45 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE George E Kistler (Degree or title) MD

22b. ADDRESS St Charles Mo

22c. DATE SIGNED 7-23-60

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL

23b. DATE 7-26-60

23c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.

23d. LOCATION (City, town, or county) ST. LOUIS (State) Mo.

24. FUNERAL DIRECTOR ADDRESS COLLIER MORTUARY ST. ANN Mo

25. DATE RECD. BY LOCAL REG. July 23-60

26. REGISTRAR'S SIGNATURE Marcella Wilson

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

AUG 4 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Sheldon Collier

Licensed Embalmer No. 338

P. O. Address St. Am

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.